REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE STATE'S DIVERSION PROGRAMS DO NOT ADEQUATELY PROTECT THE PUBLIC FROM HEALTH PROFESSIONALS WHO SUFFER FROM ALCOHOLISM OR DRUG ABUSE

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the State's alcohol and drug diversion programs for health professionals. The Board of Medical Quality Assurance needs to improve its diversion program to protect the public while rehabilitating physicians suffering from alcoholism or drug abuse. The Board of Examiners in Veterinary Medicine also needs to improve its diversion program. Finally, the Board of Dental Examiners needs to implement a diversion program as required by state law.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

SUMMARY

State law requires the Board of Medical Quality Assurance, the Board of Examiners in Veterinary Medicine, and the Board of Dental Examiners to provide diversion programs to protect the public while rehabilitating health professionals who suffer from alcoholism or drug abuse. The Board of Medical Quality Assurance, however, is not protecting the public while rehabilitating physicians suffering from alcoholism and drug abuse. In addition, the Board of Examiners in Veterinary Medicine is not ensuring that veterinarians are not under the influence of drugs or alcohol while practicing veterinary medicine, and the Board of Dental Examiners has not implemented a diversion program.

The Board of Medical Quality Assurance

The Board of Medical Quality Assurance (medical board) is responsible for licensing the State's physicians and enforcing the provisions of the Medical Practice Act. In fiscal year 1983-84, California had 105,000 licensed physicians. In June 1984, the medical board had approximately 160 participants in its diversion program for physicians suffering from alcoholism, drug abuse, or physical or mental illness. Physicians admitted into the program accept a treatment plan and agree to have their activities monitored by compliance officers and, in some cases, by other physicians acting as "practice monitors." Participants must also periodically provide urine samples, which are analyzed to detect alcohol or drugs. Physicians who do not comply with their treatment plans can be suspended from treating patients or be referred to the medical board's enforcement program for discipline.

We examined case files for 35 participants and found that participants in the diversion program are not receiving adequate supervision from compliance officers. From July 1, 1982, through

July 20, 1984, compliance officers visited 24 of the 35 participants only 150 (57 percent) of the 262 times required by diversion program policies. In addition, compliance officers did not collect urine samples from participants as frequently as required.

Problems with the performance of compliance officers have occurred because the compliance officers were not aware of diversion program policies. They have also exceeded their authority by modifying the terms of participants' treatment plans. The deputy program manager, who is responsible for supervising the compliance officers, did not realize that these problems existed because he did not have a system for tracking activities of the compliance officers.

In addition, the program manager is not ensuring that participants have practice monitors as required. Practice monitors are physicians who work in the same building as the participants and observe the participants before or while they practice medicine. Although 16 of the 35 participants in our sample were required to have practice monitors, 5 did not. Furthermore, for participants who did have practice monitors, the monitors were not fulfilling all their responsibilities. Practice monitors we interviewed told us that they did not know what their responsibilities were.

Despite the deficiencies in monitoring participants, compliance officers have documented some cases well enough to substantiate the need for disciplinary action by the diversion program. In such cases, the program manager can suspend participants from treating patients or recommend that they be terminated from the diversion program and referred to the enforcement program for disciplinary action. However, the program manager has not exercised his authority over participants who did not comply with their treatment plans. In our sample of 35 participants, we identified 3 participants who should have been suspended from treating patients because these participants had practiced medicine while using alcohol or drugs. The chief medical consultant, who is the principal supervisor of the diversion program, corroborated our assessment.

The program manager has also not recommended that participants be terminated from the program when they have repeatedly failed to comply with their treatment plans. According to the chief medical consultant and the president of the medical board's Division of Medical Quality, two participants whose files we reviewed should have been referred to a diversion evaluation committee for termination from the diversion program. The program manager allowed one of the participants to remain in the program despite repeated instances of noncompliance, including an attempt to perform surgery while under the influence of alcohol. The hospital staff had to remove this physician from the operating room when they realized that he was intoxicated. He was subsequently suspended from the hospital's medical staff, but he was not removed from the medical board's diversion program and referred to the enforcement program for disciplinary action.

The principal cause of these deficiencies is that the medical board has not properly supervised the diversion program and has not routinely reviewed the program's operations. The chief medical consultant was not supervising the diversion program because the medical board had not clarified his authority to manage the program or to review files of participants. During our review, the medical board relieved the current program manager of the diversion program of his responsibility for administering the entire program. A new program manager, whose responsibilities will include supervising participants' compliance with their treatment plans, is being recruited.

The Board of Examiners in Veterinary Medicine

The Board of Examiners in Veterinary Medicine (veterinary board) licenses veterinarians and animal health technicians. In fiscal year 1983-84, the State had 9,600 licensed practitioners. Although legislation requiring a diversion program at the veterinary board became effective January 1, 1983, the veterinary board did not fully implement its diversion program until June 1984. As of

October 31, 1984, the diversion program had eight participants. During the delay in implementing its diversion program, the veterinary board suspended all discipline of two veterinarians having problems of drug abuse. One veterinarian had been referred to the diversion program on December 27, 1983, for abusing drugs. The diversion program accepted this veterinarian into the program on June 16, 1984; during the interval, the veterinary board took no disciplinary action against the veterinarian. A second veterinarian was referred to the diversion program on August 17, 1983. As of October 31, 1984, this veterinarian had not been accepted into the diversion program, and the veterinary board had taken no disciplinary action against the veterinarian.

In addition, the program manager is not properly screening veterinarians who request admission to the program and is not adequately monitoring participants. These deficiencies exist because the veterinary board's contract with the program manager does not contain specific performance standards pertaining to screening applicants and monitoring participants. Furthermore, the executive officer of the veterinary board is not closely supervising the operation of the program.

The Board of Dental Examiners

The Board of Dental Examiners (dental board) is responsible for licensing dentists and enforcing the provisions of the Dental Practice Act. In fiscal year 1983-84, the State had 21,000 licensed dentists. State law requiring the dental board to implement a diversion program for dentists suffering from alcoholism or drug abuse became effective January 1, 1983. However, the dental board has not yet implemented a diversion program. Consequently, dentists do not have the opportunity to participate in a diversion program as an alternative to discipline.

In the absence of a diversion program, the dental board is not always disciplining some dentists suffering from alcoholism and drug

abuse. For example, the dental board received complaints about two dentists suffering from alcoholism or drug abuse; in addition, both dentists had been arrested for abusing alcohol or drugs. Although the dental board was aware of the problems of both dentists, it took little action to discipline or rehabilitate them. According to the president of the dental board, the dental board has had difficulty starting a diversion program because of staff shortages and because the dental board did not consider implementing the diversion program a high priority.

The State's Diversion Programs Have Similar Functions

In addition to the three diversion programs discussed in this report, state law effective January 1, 1985, requires diversion programs at the Board of Registered Nursing and the Board of Pharmacy. We evaluated the similarities among the State's diversion programs. If the programs were consolidated into one program, four of the programs could share the function of monitoring participants. The diversion program at the Board of Pharmacy is structured differently than the others and could not be consolidated. We could not fully evaluate the feasibility of consolidation, however, because we could not obtain all necessary data on costs.

INTRODUCTION

California has established a diversion program to rehabilitate physicians who suffer from alcoholism, drug abuse, or physical or mental illness. The State has mandated similar diversion programs for veterinarians, animal health technicians, and dentists who suffer from alcoholism or drug abuse. Moreover, legislation effective January 1, 1985, requires diversion programs for registered nurses and pharmacists suffering from alcoholism, drug abuse, or mental illness. Instead of suspending or revoking the licenses of health professionals suffering from these disabilities, licensing boards can offer rehabilitation in a diversion program. State law requires that these licensing boards rehabilitate health professionals in a manner that does not endanger the public.

The diversion program for physicians is administered by the Board of Medical Quality Assurance. The Board of Examiners in Veterinary Medicine administers the diversion programs for veterinarians and animal health technicians, and the Board of Dental Examiners is responsible for establishing a diversion program for dentists. Diversion programs for registered nurses and pharmacists will be administered by the Board of Registered Nursing and the Board of Pharmacy, respectively. In this report, we present results of our review of the diversion programs administered by the Board of Medical Quality Assurance and the Board of Examiners in Veterinary Medicine. We also reviewed the Board of Dental Examiners' efforts to implement a diversion program.

The Board of Medical Quality Assurance

The Board of Medical Quality Assurance (medical board), which consists of 19 members, is responsible for licensing physicians. The State had 105,000 licensed physicians in fiscal year 1983-84.* The medical board is also responsible for enforcing disciplinary and criminal provisions of the Medical Practice Act. In addition to its enforcement program, which investigates and disciplines physicians who violate the Medical Practice Act, the medical board implemented in 1980 a diversion program to rehabilitate physicians who suffer from alcoholism, drug abuse, or physical or mental illness. As of June 1984, the diversion program had approximately 160 participants. The diversion program's budget of approximately $465,000 for fiscal year 1984-85 comes primarily from licensing fees paid by physicians.

In August 1982, the Auditor General issued a report entitled "Review of the Board of Medical Quality Assurance" (Report P-035), which included an evaluation of how well the diversion program was monitoring its participants. The report concluded that compliance officers were not adequately monitoring participants and were not enforcing participants' compliance with treatment plans. State law requires that participants who do not comply with significant terms and conditions of their treatment plans may be terminated from the

*This total does not include physicians and surgeons licensed by the Board of Osteopathic Examiners.

diversion program. Participants terminated from the diversion program are referred to the medical board's enforcement program for possible disciplinary action.

The Auditor General's report identified participants who were not complying with significant terms and conditions of their treatment plans but who had not been terminated or referred to the enforcement program. The Auditor General recommended that the medical board establish guidelines for how frequently compliance officers should contact participants, develop a more detailed job description for compliance officers, develop performance measures for compliance officers, and develop more specific criteria for terminating participants from the diversion program.

The Board of Examiners in Veterinary Medicine

The Board of Examiners in Veterinary Medicine (veterinary board), which consists of six members, is responsible for issuing licenses to veterinarians and animal health technicians. The State had 9,600 licensed veterinarians and animal health technicians in fiscal year 1983-84. The veterinary board also enforces disciplinary and criminal provisions of the statutes for veterinary medicine.

State law requiring the veterinary board to establish a diversion program became effective January 1, 1983. In June 1984, the board fully implemented a diversion program for veterinarians and

animal health technicians who suffer from alcoholism or drug abuse. As of October 31, 1984, the diversion program had eight participants. The program's budget for fiscal year 1984-85 is approximately $50,000, which comes primarily from licensing fees paid by veterinarians and animal health technicians.

The Board of Dental Examiners

The Board of Dental Examiners (dental board), which consists of 13 members, is responsible for issuing licenses to dentists. During fiscal year 1983-84, the dental board had 21,000 licensed dentists. The dental board is also responsible for enforcing disciplinary and criminal provisions of the Dental Practice Act.

State law, effective January 1, 1983, requires the dental board to implement a diversion program for dentists suffering from alcoholism or drug abuse. Although the dental board has not established its diversion program, its budget for the diversion program for fiscal year 1983-84 was $42,000. These funds come primarily from licensing fees paid by dentists.

Diversion Programs for Registered Nurses and Pharmacists

Effective January 1, 1985, state laws require diversion programs for registered nurses and pharmacists who suffer from alcoholism, drug abuse, or mental illness. The Board of Registered

Nursing and the Board of Pharmacy, respectively, will administer these new diversion programs.

For fiscal year 1984-85, the Legislature has appropriated $95,000 for the Board of Registered Nursing and $25,000 for the Board of Pharmacy to implement their respective diversion programs. In fiscal year 1983-84, the State had 213,000 registered nurses and 27,800 licensed pharmacists.

SCOPE AND METHODOLOGY

Chapter 1261, Statutes of 1982, directed the Auditor General to review diversion programs administered by three boards within the Department of Consumer Affairs: the Board of Medical Quality Assurance, the Board of Examiners in Veterinary Medicine, and the Board of Dental Examiners. We also analyzed statutory provisions for these diversion programs and the two new diversion programs to determine which of their functions could be shared if the programs were consolidated under one administration.

To evaluate the medical board's diversion program, we reviewed pertinent state laws and regulations, policies and procedures, and other program documents. We interviewed managers of the medical board and managers of the diversion program. We also interviewed compliance officers, facilitators for group meetings, and members of the program's diversion evaluation committees. To determine how well the diversion

program is monitoring its participants, we examined case files for a sample of 35 of the approximately 160 participants in the program. Although the diversion program accepts physicians who suffer from alcoholism, drug abuse, or physical or mental illness, we limited our review to case files of physicians who were in the program because of alcoholism or drug abuse. Our review of files covers the period from July 1, 1982, through July 20, 1984.

In reviewing the veterinary board's diversion program, we examined state laws and regulations to identify the program's requirements. We interviewed the executive officer of the veterinary board and the manager of the diversion program to identify the program's policies and procedures. To determine how well the diversion program is monitoring participants, we reviewed the case files of five participants. To determine whether the diversion program is properly screening applicants to the program, we reviewed the case files of nine applicants. Our review of files covers the period from March 28, 1984, through August 7, 1984.

To evaluate the dental board's efforts to implement its diversion program, we reviewed state laws and interviewed both the president and the executive officer of the dental board. We also reviewed other documents, including budgets and minutes of board meetings. To determine how the dental board is handling dentists suffering from alcoholism or drug abuse, we reviewed a sample of cases that the dental board has under investigation and a sample of cases of

dentists who have been disciplined by the dental board and are on probation. Our review of files covers the period from January 1, 1983, through August 20, 1984.

To analyze the potential for consolidating the State's five diversion programs, we reviewed statutory provisions and identified similarities and differences among the diversion programs. We also reviewed costs for operating diversion programs at the medical board and the veterinary board. We could not compare costs for all the diversion programs because the dental board has not implemented its diversion program and because annual costs for some of the functions of the veterinary board's diversion program are not available.

CHAPTER I

THE BOARD OF MEDICAL QUALITY ASSURANCE IS NOT PROTECTING THE PUBLIC WHILE REHABILITATING PHYSICIANS SUFFERING FROM ALCOHOLISM OR DRUG ABUSE

The diversion program of the Board of Medical Quality Assurance (medical board) does not adequately monitor participants and does not take proper action against participants who fail to comply with treatment plans. We examined case files for 35 of the program's approximately 160 participants and found weaknesses in the program's monitoring activities. For example, although the medical board has established policies that specify the frequency with which compliance officers should visit participants, compliance officers made only 150 (57 percent) of 262 required visits to 24 participants from July 1, 1982, through July 20, 1984. In addition, compliance officers have not collected urine samples as frequently as required and have modified treatment plans without authority to do so. The performance of "practice monitors," who assist compliance officers in monitoring participants, has also been deficient. Without proper monitoring of participants, the medical board cannot be certain that participants are complying with their treatment plans.

Moreover, when compliance officers have identified instances of serious noncompliance by participants, the program manager of the diversion program has not suspended participants from treating patients and has not referred participants to the program's diversion evaluation committees. These committees can terminate participants from the

diversion program and refer them to the enforcement program for discipline. Because the program manager has not exercised his authority over participants who did not comply with their treatment plans, some participants continued to treat patients while using alcohol or drugs; one participant even attempted to perform surgery while intoxicated. These weaknesses in monitoring and disciplining participants have developed because the medical board is not adequately overseeing the diversion program.

DESCRIPTION OF THE DIVERSION PROGRAM

The medical board's diversion program was designed to identify and rehabilitate physicians who suffer from alcoholism, drug abuse, or physical or mental illness and to protect the public while rehabilitating these physicians. Participation in the diversion program is voluntary. Physicians enter the diversion program either on their own volition or when the medical board's enforcement program is investigating complaints against them. When the board's investigation determines that a physician is suffering from alcoholism, drug abuse, or physical or mental illness, investigators recommend the physician to the diversion program. If the physician enters the diversion program, the enforcement program halts the investigation. The investigation is resumed, however, if the physician quits the diversion program before successfully completing it or if the diversion program terminates the physician from the program for failing to comply with the treatment plan.

The program manager of the diversion program and a medical consultant from the medical board screen physicians applying to the program to determine their eligibility. The medical board's five "diversion evaluation committees," each consisting of five members with expertise in alcoholism and drug abuse, evaluate physicians for participation in the diversion program. When a committee accepts a physician as a participant in the program, it assigns a member of the committee as a case consultant for the physician.

The diversion evaluation committees design individual treatment plans for rehabilitation of each participant. These treatment plans can extend from three to five years. In designing treatment plans, committees decide whether to permit physicians to continue practicing medicine while undergoing treatment, whether physicians need supervision while treating patients, and whether they need restrictions on their permits for prescribing drugs. The Business and Professions Code requires that all board and committee records pertaining to physicians' treatment be kept confidential.

One of the main components of treatment plans is the requirement that participants attend group meetings. Participants are usually required to attend group meetings twice a week. The group meetings, which are similar to support group meetings of Alcoholics Anonymous or Narcotics Anonymous, provide the diversion program with its most frequent contact with participants. Facilitators who conduct these meetings assist the diversion program's staff in monitoring the

participants' compliance with treatment plans. Facilitators observe the participants and report to the program if they suspect that participants have resumed the use of alcohol or drugs. Facilitators also report on the attendance of participants and may request that participants provide urine samples for testing.

Physicians become participants in the diversion program when they sign their treatment plans. In their treatment plans, they agree to cooperate with the program's monitoring activities, including supervision and surveillance by compliance officers and by facilitators of group meetings. The diversion program has four compliance officers who are required to monitor participants' compliance with their treatment plans.

Compliance officers perform this monitoring function by visiting participants in their homes, in offices or hospitals, or in group meetings. Generally, compliance officers must visit participants once a month, but this period may be extended to two months for participants who have abstained from using alcohol or drugs for a year and who meet several other criteria. Compliance officers also monitor participants by collecting urine samples for laboratory analysis to test for alcohol or drug use. Compliance officers must also submit to the deputy program manager reports on participants' activities.

Some participants must also obtain "practice monitors," who assist compliance officers in monitoring participants' compliance with treatment plans. These practice monitors are physicians who work in the same buildings as the participants. They are responsible for observing the participants' condition before the participants practice medicine. Some practice monitors also supervise participants when the participants are practicing medicine. The program manager and the deputy program manager are responsible for ensuring that participants comply with their treatment plans and for supervising the monitoring of participants.

In instances of serious noncompliance by participants, the program manager can instruct participants to stop treating patients for a specified period. The program manager can also refer participants to diversion evaluation committees. The committees can terminate participants from the diversion program.

DEFICIENCIES IN MONITORING PARTICIPANTS

The monitoring activities of the medical board's diversion program are deficient. We found that compliance officers have not monitored participants as required and that the program's practice monitors have not fulfilled their responsibilities.

Compliance Officers Are Not Adequately Monitoring Participants

Policies of the diversion program require that compliance officers monitor participants to ensure that they are complying with all provisions of their treatment plans. To determine if compliance officers are visiting participants as required, we reviewed case files for 35 participants. We compared the total number of visits required from July 1, 1982, through July 20, 1984, with the number of visits made. We identified significant deficiencies in 24 of the 35 cases. For those 24 participants, compliance officers made only 150 (57 percent) of the 262 visits required.

Several examples illustrate the infrequency with which compliance officers visited participants. In one case, a compliance officer was required to visit monthly a participant who had entered the diversion program on April 11, 1984, for drug abuse. From April 11, 1984, through July 20, 1984, the compliance officer had not visited the participant. In another case, a compliance officer who was required to contact a participant 20 times from July 1, 1982, through July 20, 1984, made only 10 of the required visits. The compliance officer let over five months elapse between 2 visits.

When we asked compliance officers why they did not visit participants as often as required, they said that they believed that they were performing all the required visits. We concluded that they did not understand several aspects of the diversion program's policies.

For example, although the job description for compliance officers specifies that they must have face-to-face contact with participants, one compliance officer believed that telephoning participants was sufficient in some cases. In fact, this compliance officer has never met in person a participant he has been responsible for monitoring since December 1983.

We also discovered another reason that compliance officers did not visit participants as required: compliance officers overstepped their authority and independently decided that participants did not need as much supervision as the diversion program requires. The policies of the diversion program specify that only the management of the diversion program is authorized to permit deviations from the program's policies. Yet one compliance officer who was required to visit a participant once every other month told us that he had not visited the participant for six months. He said that he thought the participant was doing well and did not need as much supervision.

In addition to not visiting participants as required, compliance officers are not following the diversion program's policies related to collecting urine samples from participants. The policies require compliance officers to collect urine samples from participants once every month until the participants have abstained from alcohol and drugs for one year. Thereafter, the compliance officers collect samples every four months. A laboratory tests the urine samples for alcohol and drugs and sends the results to the program manager.

To determine whether compliance officers are collecting urine samples in accordance with the diversion program's policies, we reviewed case files for the 35 participants in our sample. Because we were testing the requirement that compliance officers obtain urine samples at least monthly, we excluded from our review 10 of the participants who were required to provide samples less frequently. For the 25 remaining participants, compliance officers did not collect 107 (67 percent) of the 188 urine samples required.

In addition to the requirement that compliance officers obtain urine samples monthly, compliance officers are also required to collect urine samples even more frequently if one or more of the following three conditions apply: laboratory tests detect alcohol or drugs in participants' urine samples, the diversion program suspects that participants are using alcohol or drugs, or participants are not attending group meetings.

Sixteen of the 35 participants had used alcohol or drugs at least once since signing their treatment plans. Compliance officers should have collected urine samples more frequently from these participants. However, for 9 (56 percent) of the 16 participants, compliance officers did not increase the frequency with which they collected urine samples.

In one case, two of the conditions requiring increased collection of urine samples pertained to a participant whom the medical

board had referred to the diversion program for abusing drugs, including cocaine. Although a laboratory test revealed that the participant had been using marijuana and although the participant had missed more than half the group meetings he was required to attend for two months, the compliance officer did not increase the frequency with which he collected urine samples from the participant.

Compliance officers are not collecting urine samples in accordance with the diversion program's policies for the same reasons that they are not visiting participants as frequently as required: they are not aware of program policies, and they exceed their authority in modifying treatment plans. Despite the fact that the job description for compliance officers includes the policies for collecting urine samples, one compliance officer told us that the program's policies do not specify a minimum frequency for collecting urine samples. This compliance officer also exceeds his authority in modifying participants' treatment plans. Because he believes that some participants cannot afford the laboratory tests, he sometimes does not collect the urine samples or else he collects them and discards them.

The final problem with the performance of the compliance officers is in their recordkeeping. The diversion program's policies specify that compliance officers must submit written reports to the deputy program manager after contacting participants. These "compliance reports" list, for example, whether participants are complying with the terms and conditions of their treatment plans,

whether the compliance officers collected urine samples, and whether the compliance officers interviewed the participants at their homes, in their offices or hospitals, or in group meetings. However, these reports are not always complete or accurate. In many instances, compliance officers stated on their reports that certain terms and conditions did not apply to participants even though the participants' treatment plans specified those terms and conditions.

While the diversion program's compliance officers have been deficient in monitoring participants, the program's management has been similarly deficient in monitoring the performance of the compliance officers. Before our review of participants' case files, the deputy program manager, who is responsible for supervising the compliance officers, told us that he was not aware of deficiencies in the performance of the compliance officers. He said that he reviewed their compliance reports but had no formal system for comparing the work they reported with work they were required to do for the participants. He added that he did not track the frequency with which compliance officers visited participants or collected urine samples, and he did not compare compliance reports with participants' treatment plans to ensure that compliance officers were monitoring all significant terms and conditions.

The deputy program manager explained that problems that we identified in the performance of the compliance officers persisted because he did not know about them and, therefore, could not provide

sufficient training and guidance to correct them. During our review, the deputy program manager initiated action to correct some of the deficiencies that we identified. He now tracks the compliance officers' contacts with participants and with practice monitors.

Practice Monitors Are Not Monitoring Participants

We also found deficiencies in the diversion program's use of practice monitors. Practice monitors are physicians who work in the same buildings as the participants. A practice monitor is responsible for observing a participant's condition either before the participant practices medicine or while the participant practices medicine.

Sixteen of the 35 participants in our sample were required to have practice monitors; 5 of the 16, however, did not have practice monitors. For example, one participant suffering an alcohol and drug abuse problem entered the diversion program in April 1982. The participant's treatment plan requires her to have a practice monitor who both observes her before she practices medicine and supervises her while she practices medicine. However, this participant never obtained a practice monitor. The deputy program manager told us that the participant resisted having a practice monitor. We found no evidence in the case file that the diversion program took any steps to enforce this provision of the participant's treatment plan.

In another instance, a participant's practice monitor was not eligible to be a practice monitor. A 1983 memorandum from the assistant executive director of the medical board to the program manager of the diversion program stated that participants in the diversion program are not eligible to be practice monitors for other participants. Yet we found a case in which one participant was monitoring another. Even more noteworthy, the participant acting as practice monitor also had a practice monitor.

Most of the participants who were required to have practice monitors did have appropriate monitors. However, some practice monitors were not fulfilling all of their responsibilities. We interviewed five practice monitors to determine their monitoring procedures. Two of the practice monitors were required to observe their participants before the participants practiced medicine and to submit quarterly reports to the program manager on the participants' condition. One practice monitor said that he sees the participant 4 to 5 times a week but does not prepare quarterly reports. The other practice monitor said that he sees the participant once every 2 to 4 weeks. He also does not submit quarterly reports.

The practice monitors told us that they do not know what their responsibilities are. They said that they do not receive a copy of the participants' treatment plans, which outline the duties of practice monitors. Furthermore, the compliance officers are not routinely contacting practice monitors to inform them of their responsibilities.

One physician, who has been a practice monitor since October 1983, told us that a compliance officer never visited him to discuss the condition of the participant he monitors. Another practice monitor said that he does not even know whom to contact if the participant he monitors is having problems.

However, practice monitors would not necessarily be helped if compliance officers did visit and explain their duties to them. Some of the compliance officers themselves do not fully understand the duties of a practice monitor. Although 11 of the 16 treatment plans that require practice monitors specifically require practice monitors to collect urine samples, one compliance officer told us that practice monitors do not have to collect urine samples from participants.

These problems regarding the responsibilities of practice monitors result, in part, because the diversion program does not have a detailed description of the duties of a practice monitor. Although treatment plans state that practice monitors should observe participants and should, in some cases, collect urine samples, the treatment plans do not specify how often or how carefully practice monitors should observe the participants. The plans also do not indicate how often urine samples should be collected.

DEFICIENCIES IN SUSPENDING AND TERMINATING PARTICIPANTS

Despite the deficiencies in monitoring participants, compliance officers do document some cases well enough to substantiate the need for disciplinary action by the diversion program. The diversion program's policies state that the program manager can suspend participants from practicing medicine or refer them to diversion evaluation committees. The diversion evaluation committees can terminate participants from the diversion program and refer them to the enforcement program for possible disciplinary action; such action can include revoking their licenses to practice medicine. The program manager, however, did not suspend some participants in our sample who should have been suspended and did not refer to diversion evaluation committees some participants who should have been terminated from the program.

The Program Manager Is Not Properly Suspending Participants From Treating Patients

When participants sign their treatment plans, they agree to permit the program manager of the diversion program to suspend them from practicing medicine if they practice medicine while under the influence of alcohol or drugs, if they refuse to follow their treatment programs, or if they refuse to provide urine samples. Although the program manager cannot suspend a participant's license to practice medicine, the program manager can instruct the participant not to treat patients for a specified period.

In our sample of 35 participants, we identified 3 participants who should have been suspended from treating patients because these participants had practiced medicine while using alcohol or drugs. The chief medical consultant of the medical board, who supervises the diversion program, corroborated our assessment. None of these participants, however, had been suspended from practicing medicine.

The following description of a participant who was suffering from alcoholism illustrates the program manager's reluctance to suspend participants. On four separate occasions over a three-month period, urine samples collected from the participant during his office hours revealed that he was under the influence of alcohol. The participant also admitted to the facilitator of his group meetings that he had been drinking alcohol. Even though the program manager had this evidence that the participant was under the influence of alcohol during his office hours, he did not suspend the participant from practicing medicine. He told us that the participant was not a risk to the public.

The program manager's supervisor, the chief medical consultant, did not agree. He stated that this participant could have endangered his patients' health since he was using alcohol during his office hours. The chief medical consultant told us that the program manager should have either hospitalized the participant for alcoholism or suspended him from treating patients.

The Program Manager Is Not Recommending That Participants Be Terminated From the Program

Policies of the diversion program require the program manager to refer to diversion evaluation committees participants who repeatedly fail to comply with their treatment plans. The California Administrative Code states that diversion evaluation committees can terminate from the program participants who fail to comply with their treatment plans, who have not substantially benefited from the program, or whose continued participation creates too great a risk to the public. When committees terminate a participant whom the medical board referred to the diversion program, the program manager is required to refer this participant back to the medical board for possible disciplinary action. Disciplinary action can include revoking a participant's license to practice medicine.

Two of the three participants who should have been suspended from treating patients were repeatedly violating significant terms and conditions of their treatment plans. Yet the program manager did not refer them to a diversion evaluation committee for termination from the program. We reviewed these cases with the chief medical consultant and the president of the medical board's Division of Medical Quality. The Division of Medical Quality is responsible for establishing policies for the diversion program. The chief medical consultant and the president both agreed that these two participants should have been terminated from the program because they were a risk to the public.

The following description of one of the participants illustrates the program manager's lack of proper action. The medical board had referred the participant to the diversion program for alcoholism. His treatment plan required that he abstain from drinking alcohol and that he attend two group meetings each week. Our review of this case disclosed three separate instances of noncompliance with the participant's treatment plan. First, the compliance officer reported that the participant was not attending group meetings. Second, the compliance officer reported that he detected the odor of alcohol on the participant's breath on a day that the participant was treating patients. In addition, the compliance officer reported that the participant's practice monitor was very concerned because he believed that the participant was drinking alcohol heavily and taking drugs. The compliance officer consistently reported these instances of noncompliance to the program manager. However, the program manager allowed the participant to continue to treat patients and to participate in the diversion program.

The third instance of noncompliance was more serious: a coordinator for one of the medical board's four medical quality review committees reported that a participant had attempted to perform surgery while under the influence of alcohol. The hospital's staff suspected that the participant had been drinking and removed him from the operating room. Laboratory tests revealed that the physician had been legally drunk. Subsequently, the hospital administration suspended the participant from the hospital's medical staff, but the participant was

not removed from the medical board's diversion program and referred to the enforcement program for discipline.

The diversion program's policies require the program manager to discuss serious cases of noncompliance with the participant's case consultants. Case consultants are members of diversion evaluation committees. This participant's case consultant told us, however, that the program manager had never contacted him to discuss these instances of noncompliance. Furthermore, he stated that he did not know that the participant had attempted to perform surgery while under the influence of alcohol.

LACK OF OVERSIGHT BY THE MEDICAL BOARD

The objective of the diversion program is to protect the public while rehabilitating physicians suffering from alcoholism, drug abuse, or physical or mental illness. In interpreting this objective, the medical board has declared that its first priority is to ensure that it protects the public. Successfully rehabilitating physicians comes second.

In spite of the medical board's determination that the diversion program must protect the public, the medical board's staff has not developed adequate procedures for supervising the diversion program and for ensuring that the diversion program is protecting the public. The medical board's chief medical consultant, for example, is

responsible for supervising the diversion program, but he was uncertain about his authority over the program. He told us that the medical board has not adopted a policy that clarifies his role and responsibilities for the diversion program. He did not even know whether he had authority to manage the program or to review participants' files.

The chief medical consultant said that he has relied on the program manager of the diversion program to ensure that compliance officers are adequately monitoring participants and that participants are complying with their treatment plans. The program manager submits monthly and quarterly reports to inform the chief medical consultant about the program's status. The quarterly reports provide an overview of the diversion program since its inception in 1980, including the total number of participants, the number of participants terminated from the program, and the types of drugs that participants abuse most frequently. The monthly reports contain information on physicians whom the medical board referred to the diversion program. These monthly reports indicate whether the physician is an applicant, an inactive participant, or an active participant.

The quarterly and the monthly reports do not, however, contain enough information on the participants' progress to enable the chief medical consultant to assess the performance of the diversion program. The reports do not summarize the participants' compliance with their treatment plans or reveal any instances of significant noncompliance by

participants. Thus, the chief medical consultant does not receive sufficient information to enable him to manage the program properly. Recently, the medical board did implement improved reporting procedures. As of September 18, 1984, for example, the program manager must now report to the chief medical consultant participants who are not complying with their treatment plans.

In addition to inadequately supervising the diversion program, the medical board has conducted few reviews of the diversion program's entire operation. Although the diversion program has existed for over four years, the medical board has reviewed it only twice: once in 1982 to verify the deficiencies in the program that the Auditor General identified in the 1982 report and once in 1983 to determine whether the program manager had implemented the Auditor General's recommendations.

During our review, the medical board relieved the current program manager of the diversion program of his responsibility for administering the entire program. He will be in charge of treatment and rehabilitation for participants. A new program manager, whose responsibilities will include supervising participants' compliance with their treatment plans, is being recruited.

CONCLUSION

The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. Compliance officers are not visiting participants and collecting urine samples as frequently as the program requires, some participants do not have practice monitors as required, and practice monitors are not performing all their required duties. Moreover, the program manager is not exercising his authority over participants who do not comply with their treatment plans. He has not suspended participants from treating patients or referred to diversion evaluation committees participants who repeatedly failed to comply with their treatment plans. The medical board has allowed these problems to develop because it has not adequately supervised the diversion program.

RECOMMENDATIONS

To improve the monitoring activities of its compliance officers, the diversion program of the Board of Medical Quality Assurance should implement the following measures:

- Provide compliance officers with training in the diversion program's policies and procedures. This

training should specify how often compliance officers should visit participants, what constitutes a visit, and how often to collect urine samples. The training should also emphasize the need for compliance officers to increase monitoring of participants who do not comply with their treatment plans. The training should stress the importance of accurately completing compliance reports and the compliance officer's lack of authority to independently modify treatment plans.

- Improve the system for tracking the compliance officers' activities in monitoring participants.

To ensure that participants have practice monitors and that practice monitors perform their responsibilities, the diversion program should take the following steps:

- Develop new guidelines for practice monitors that describe the observations they must make of participants, how frequently they must observe the participants, how often they must collect urine samples, and what information they should include in their quarterly reports.

- Provide compliance officers with training in the diversion program's policies on practice monitors and in

the new guidelines for practice monitors. This training should emphasize the need for compliance officers to contact practice monitors initially to inform them of their responsibilities. The training should also stress the requirement that compliance officers contact practice monitors regularly thereafter.

- Develop a system to ensure that the diversion program identifies participants' practice monitors, that compliance officers are contacting practice monitors, and that practice monitors are fulfilling their responsibilities.

To ensure that participants are suspended from treating patients or terminated from the diversion program when necessary, the medical board should take the following actions:

- Specify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination.

- Develop a system to ensure that the program manager consults with members of diversion evaluation committees when participants violate significant terms and conditions of their treatment plans.

Finally, to improve the medical board's oversight of the diversion program, the medical board should develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly.

CHAPTER II

THE BOARD OF EXAMINERS IN VETERINARY MEDICINE NEEDS TO IMPROVE ITS DIVERSION PROGRAM FOR VETERINARIANS AND ANIMAL HEALTH TECHNICIANS SUFFERING FROM ALCOHOLISM OR DRUG ABUSE

The Board of Examiners in Veterinary Medicine (veterinary board) took nearly 18 months to fully implement a diversion program for veterinarians and animal health technicians suffering from alcoholism or drug abuse. Moreover, the diversion program, now operational, is not administered properly. The program manager has not followed statutory requirements for screening applicants to the diversion program and has not adequately monitored participants' compliance with treatment plans. As a result, the veterinary board is not fulfilling its responsibility to ensure that veterinarians and animal health technicians do not work while using alcohol or drugs.

DESCRIPTION OF THE DIVERSION PROGRAM

The diversion program of the veterinary board is voluntary and accepts veterinarians and animal health technicians who refer themselves to the program. Veterinarians and animal health technicians about whom the veterinary board has received complaints may also enter the program voluntarily if the board's investigations disclose that they are suffering from alcoholism or drug abuse.

The program manager interviews applicants and refers them to one of the program's two diversion evaluation committees for

evaluation. Each diversion evaluation committee consists of five members who have expertise in rehabilitating alcoholics or drug abusers. The committees accept applicants into the program and design individual treatment plans for rehabilitation. The applicants become participants when they sign their treatment plans and thereby agree to comply with their treatment plans and to submit to supervision and surveillance by the program manager.

The program manager is responsible for monitoring the participants' compliance with their treatment plans. If participants fail to comply with their treatment plans, the program manager can refer them to a diversion evaluation committee for termination from the program.

DELAY IN IMPLEMENTING THE DIVERSION PROGRAM

The veterinary board was slow in implementing a diversion program. Although state law mandating a diversion program for the veterinary board became effective on January 1, 1983, the veterinary board could not contract with a program manager until the Department of Finance provided funds for implementing the diversion program on July 1, 1983.

In October 1983, the veterinary board formed its first diversion evaluation committee. The committee met in October and December of 1983 and in January of 1984 to discuss implementing the

diversion program. However, the diversion evaluation committee could not accept veterinarians or animal health technicians into the diversion program until the necessary regulations were filed with the Secretary of State.

Section 11343 of the California Government Code requires the veterinary board to submit to the Office of Administrative Law proposed regulations for the diversion program. The regulations become part of the California Administrative Code. The veterinary board could not accept veterinarians and animal technicians into its diversion program until the Office of Administrative Law approved the regulations and filed them with the Secretary of State. In November 1983, the executive officer of the veterinary board submitted a draft of the regulations to the Office of Administrative Law. He later withdrew that draft and submitted another one that was approved and filed on March 28, 1984. The regulations became effective on the date they were filed.

As of March 28, 1984, the veterinary board had nine applicants for its diversion program. Four of the nine had been referred to the program by the executive officer. On June 16, 1984, almost 18 months after the veterinary board was required to establish a diversion program, a diversion evaluation committee screened and accepted its first participant into the diversion program. According to the program manager, seven additional applicants had been accepted as of October 31, 1984.

During the 18-month delay, the veterinary board suspended all disciplinary proceedings against two veterinarians who had been identified as suffering from drug abuse. For example, on December 27, 1983, the veterinary board's executive officer referred a veterinarian to the diversion program for abusing drugs. From December 27, 1983, until June 16, 1984, when the diversion evaluation committee accepted this veterinarian into the diversion program, the veterinary board took no disciplinary action against the veterinarian.

The executive officer had also referred a second veterinarian to the program on August 17, 1983, for abusing drugs. Although this veterinarian was an applicant for the diversion program on March 28, 1984, the diversion evaluation committee had not screened or accepted this veterinarian into the diversion program as of October 31, 1984. From August 17, 1983, through October 31, 1984, the veterinary board did not take any disciplinary action against this veterinarian.

IMPROPER SCREENING OF APPLICANTS

The program manager of the diversion program is not properly screening applicants to the diversion program. Sections 4866(b) and 4868(a) of the Business and Professions Code specifically require that "administrative physicians," who act as medical consultants to the program manager, "must examine veterinarians and animal health technicians who request admission to the diversion program." The code further specifies that each diversion evaluation committee shall

"consider the recommendation of the administrative physician on the admission of the veterinarian or animal health technician to the diversion program."

The program manager, however, has not complied with these requirements in the Business and Professions Code. Although the program manager selected as administrative physicians one medical consultant for northern California and one for southern California, the program manager told us that administrative physicians had not interviewed the nine applicants for the diversion program. Despite the fact that the statutes require examinations by administrative physicians, the program manager asserts that he does not need the administrative physicians' medical opinion of each applicant's condition.

INADEQUATE MONITORING OF PARTICIPANTS

In addition to not implementing proper screening for applicants to the diversion program, the program manager has not implemented adequate systems for monitoring participants' compliance with their treatment plans. In contrast to the diversion program of the Board of Medical Quality Assurance, which has hired staff for monitoring participants and has established basic monitoring procedures, the veterinary board's program manager himself monitors the participants' compliance with their treatment plans, and he does so without adequate monitoring procedures.

The program manager told us that he talks on the telephone with the participants at least once a week to determine how well they are progressing. He said that he also tries to visit the participants at least once every two to three months. He also stated that he planned to collect urine samples from participants.

We reviewed files for the first five participants in the diversion program for the period from June 18, 1984, through August 7, 1984, to determine how well the program manager was monitoring the participants' compliance with their treatment plans. According to the files, the program manager had not visited any of the five participants during that period. In addition, he had not collected any urine samples.

The program manager told us that he does not have time to monitor participants' compliance adequately since he works only half-time for the diversion program. However, as of October 31, 1984, he had only eight participants to monitor. In contrast, each of the medical board's compliance officers, who work full-time, monitors from 30 to 60 cases. Based on this workload comparison, we concluded that monitoring eight participants is not an unreasonable workload for the program manager of the veterinary board.

The program manager also stated that the program does not have sufficient funds to hire staff to monitor participants. However, the program manager does not have to rely solely on the diversion program's

budget to fund monitoring activities. The executive officer told us that the veterinary board, which is already paying costs incurred by the program's diversion evaluation committees, could also pay for staff to monitor compliance of participants.

Although the program manager does not have paid staff to monitor participants, he uses volunteers from the community to assist him in monitoring the participants' compliance with treatment plans. These volunteers are usually recovering alcoholics or drug abusers associated with Alcoholics Anonymous or Narcotics Anonymous. However, because these volunteers are not state employees or employees of the program manager, they are not accountable to the program manager.

REASONS FOR DEFICIENCIES IN THE DIVERSION PROGRAM

Deficiencies in the diversion program have occurred in part because the program manager's contract lacks performance standards. The veterinary board used the competitive bidding process to procure the services of this program manager for fiscal years 1983-84 and 1984-85. As part of his contractual responsibilities, the program manager is responsible for screening applicants for the diversion program, implementing treatment plans, supervising participants' compliance with program requirements, and submitting quarterly progress reports to the board's executive officer.

The contract also requires the program manager to maintain a surveillance program for monitoring participants. However, this provision of the contract does not specify the type of monitoring program or the standards for monitoring participants; such standards would state how frequently the program manager must contact participants and collect urine samples.

Lack of close supervision of the diversion program by the executive officer of the veterinary board is another reason for the problems in this diversion program. Although the executive officer told us that he reviews quarterly reports from the program manager and reads minutes of meetings of the diversion evaluation committees, he said that he has never actually reviewed the program's operation to ensure that it is complying with the state law that created the program. The executive officer said that he lets the program manager interpret the law himself.

CONCLUSION

The Board of Examiners in Veterinary Medicine took nearly 18 months to fully implement its diversion program. Moreover, the diversion program is not screening applicants appropriately. Additionally, the program manager is not adequately monitoring participants in the program. Deficiencies in the diversion program exist because the veterinary board's contract with the program manager lacks

specific performance standards for monitoring participants and because the executive officer of the diversion program is not closely supervising the program.

RECOMMENDATIONS

To improve the performance of its diversion program, the Board of Examiners in Veterinary Medicine should take the following actions:

- Develop a system to monitor the program manager's performance to ensure that the program manager is implementing provisions of state law and of his contract. The diversion program should require proper screening of applicants.

- Develop specific performance standards in the program manager's contract for monitoring participants. The standards should include the frequency with which the program manager should contact participants and collect urine samples.

- Augment the diversion program's budget to enable it to contract for the services of a compliance officer to monitor the program's participants.

CHAPTER III

THE BOARD OF DENTAL EXAMINERS HAS NOT IMPLEMENTED A DIVERSION PROGRAM FOR DENTISTS SUFFERING FROM ALCOHOLISM OR DRUG ABUSE

The statutes mandating a diversion program for the Board of Dental Examiners (dental board) became effective on January 1, 1983. Although nearly two years have passed since that law went into effect, the dental board still has not implemented its diversion program. Consequently, dentists suffering from alcoholism or drug abuse do not have the opportunity to enter the diversion program as an alternative to disciplinary action. Moreover, in the absence of a diversion program, the dental board is not always disciplining some dentists suffering from alcoholism or drug abuse. For example, although the dental board received complaints about two dentists who were abusing alcohol or drugs and although both dentists had arrest records, the dental board did not restrict their licenses to practice dentistry. According to the president of the dental board, the dental board had difficulty starting the diversion program because of lack of staff and because the dental board did not give high priority to implementing the diversion program.

STATUS OF THE DIVERSION PROGRAM

State law effective January 1, 1983, requires that the dental board establish a diversion program for dentists suffering from alcoholism or drug abuse. Traditionally, when the dental board

determined that a dentist was using alcohol or drugs to an extent that impaired the dentist's ability to practice dentistry safely, the dental board revoked or suspended the dentist's license or placed the dentist on probation. The diversion program, which would provide an alternative to disciplinary action, is designed to rehabilitate dentists in a manner that does not endanger the public.

The dental board still has not implemented its diversion program. The dental board has not developed regulations for the California Administrative Code, has not established criteria for selecting diversion evaluation committees, and has not established criteria for accepting, denying, or terminating dentists in the diversion program.

Some dentists suffering from alcoholism or drug abuse who were not under investigation by the dental board have been referred by various sources to group meetings conducted by facilitators for the diversion program of the Board of Medical Quality Assurance. However, these referrals to the medical board's group meetings do not constitute a diversion program because the dental board has not implemented any of the statutory requirements for its diversion program.

IMPROPER HANDLING OF DENTISTS SUFFERING FROM ALCOHOLISM OR DRUG ABUSE

To determine how, in the absence of a diversion program, the dental board was handling cases involving dentists suffering from

alcoholism or drug abuse, we reviewed 12 case files for dentists in various stages of the dental board's enforcement process: under investigation, pending prosecution, recommended for diversion, or on probation.

In one case, the dental board diverted from discipline one dentist suffering from drug abuse even though the dental board does not have a diversion program. The dental board's former executive officer diverted this dentist from discipline and entrusted his care to a psychiatrist. Nothing in the state law creating the diversion program permits the executive officer to make such a decision. The Business and Professions Code states that the dental board's diversion evaluation committee is responsible for evaluating a dentist's impairment, for accepting a dentist into the diversion program, and for designing a treatment plan with which a dentist is required to comply.

Moreover, the dental board has not handled properly two other dentists who have problems of alcoholism or drug abuse. Although the dental board received complaints against these dentists and although both dentists have arrest records, the dental board has done nothing to rehabilitate these dentists or to restrict their licenses to practice dentistry.

One of the two dentists has been abusing drugs since November 1981. This dentist was arrested in August 1982 and charged with possessing narcotics and with obtaining narcotics by fraud and

deceit. The police found that the dentist was prescribing for his own use inordinate amounts of demerol, a potent narcotic used to relieve pain.

In July 1983, a deputy attorney general told the dental board that, although he had prepared an "accusation for disciplinary action" against the dentist, he would recommend that the dental board consider this dentist as a candidate for the diversion program. In October 1983, the deputy attorney general learned that the dental board's former executive officer was considering placing the dentist in the diversion program rather than taking disciplinary action. We could not determine what diversion program the executive officer thought he would divert this dentist to.

In August 1984, two years after this dentist was arrested, the dental board had still not initiated any action against him. In August 1984, the deputy attorney general informed the dental board that prosecution would be more difficult because the dental board had taken no action on the case. The deputy attorney general recommended that the dental board hold an informal conference with this dentist to discuss his problem. That conference was conducted in November 1984.

In the second case, the dental board received a complaint in March 1983 about a dentist who was allegedly using alcohol and drugs; a patient complained to the dental board that this dentist was "nodding off" while treating her. In December 1983, the police arrested the

dentist for driving under the influence of alcohol or drugs. The dental board's investigator recommended that the dentist be considered for the diversion program because he believed that the dentist needed treatment rather than discipline for his alcoholism and drug abuse. This dentist, who has been practicing dentistry intermittently since February 1983, is still free to practice without any restrictions on his license.

REASONS FOR NOT IMPLEMENTING A DIVERSION PROGRAM

During fiscal year 1983-84, the Department of Finance approved a $42,000 budget specifically for the dental board's diversion program. Despite this appropriation, the president of the dental board stated that the board had no staff available in calendar year 1983 to implement the diversion program because of the Governor's freeze on hiring. However, a budget analyst with the Department of Finance, which is responsible for approving funding for the dental board, told us that the dental board could have applied for a waiver to the freeze. The board could then have contracted for the services necessary to develop and implement a diversion program. The dental board did not pursue this option.

The dental board's president also explained that the board had difficulty starting a new program in calendar year 1984 because of high turnover among board members. She said that as the board members change, the board's priorities change. The new board members placed a

higher priority on designing new examinations for dental practitioners and inspecting the practices of dentists licensed to administer anesthetics than on implementing the board's diversion program. Because of these "higher priorities," dentists suffering from alcoholism or drug abuse continue to practice dentistry without restriction or opportunity for rehabilitation, and the dental board cannot ensure that it is protecting the public from such dentists.

CONCLUSION

The Board of Dental Examiners has not implemented a diversion program as required by state law. Consequently, dentists do not have the opportunity to participate in a diversion program. Furthermore, the dental board is not disciplining some dentists suffering from alcoholism or drug abuse.

RECOMMENDATIONS

Within six months from the date this report is issued, the Board of Dental Examiners should submit to the Office of Administrative Law regulations for implementing a diversion program. These regulations should establish criteria for selecting diversion evaluation committees and for accepting or denying applicants and terminating participants. Once the regulations are adopted, the dental board should hire staff to

implement the provisions of state law and regulations. The board should then commence accepting dentists into the diversion program.

CHAPTER IV

THE STATE'S DIVERSION PROGRAMS HAVE SIMILAR FUNCTIONS

In addition to the diversion programs required at the Board of Medical Quality Assurance, the Board of Examiners in Veterinary Medicine, and the Board of Dental Examiners, state law effective January 1, 1985, requires diversion programs at the Board of Registered Nursing (nursing board) for nurses suffering from alcoholism, drug abuse, or mental illness and at the Board of Pharmacy (pharmacy board) for pharmacists suffering from alcoholism, drug abuse, or mental illness. We were asked to determine which functions could be shared if all five diversion programs were consolidated. We were also asked to determine the cost of each function that the diversion programs perform.

We reviewed statutory provisions for all the diversion programs and identified the similar functions among the programs. We concluded that four of the diversion programs could share the function of monitoring program participants. However, we were unable to compare the costs for each function because not all necessary data were available.

SIMILARITIES AND DIFFERENCES AMONG DIVERSION PROGRAMS

The diversion programs of the five boards have similar functions. For example, all the boards develop standards for accepting applicants and for terminating participants, and all boards require treatment plans for participants. In addition, all boards require monitoring of participants. Requirements for monitoring participants are similar for all boards, and each board requires its participants to comply with their treatment plans and to submit to supervision or surveillance by the diversion program. Finally, all boards can terminate participants who do not comply with treatment plans.

The methods of implementing these functions differ among the boards, however. For example, only the medical board and the veterinary board must select and use administrative physicians to examine applicants to the diversion programs. In addition, state law requires only four of the boards to establish diversion evaluation committees. The required makeup of the diversion evaluation committee differs also. The medical board's diversion evaluation committees must consist of four physicians and one member of the public; the veterinary board's diversion evaluation committees must consist of three veterinarians and two members of the public. The diversion evaluation committees of the nursing board must consist of three registered nurses, one physician, and one member of the public. State law does not specify the makeup of the diversion evaluation committees of the dental board, which has not established a committee.

The diversion evaluation committees for each board are required to perform similar tasks, however. They are responsible for evaluating and accepting health professionals into the diversion programs, for designing individual treatment plans for participants, and for reviewing and selecting treatment facilities for participants. The diversion evaluation committees are also empowered to terminate participants from the diversion programs for failing to comply with their treatment plans.

The diversion program at the pharmacy board is different from those of the other boards. Although this board is required to develop standards for accepting applicants into the diversion program, the pharmacy board selects "employee assistance programs" to administer the diversion program. Employee assistance programs are organizations that provide assessments and referral services for alcoholism, drug abuse, or mental illness.

The pharmacy board's employee assistance programs assume some responsibilities performed by diversion evaluation committees at other boards. They administer the diversion program, and they are responsible for evaluating applicants and for selecting treatment facilities for participants. The pharmacy board also requires employee assistance programs to monitor participants' compliance with treatment plans and to terminate from the program participants who fail to comply with their treatment plans. In addition, the pharmacy board is

required to monitor the employee assistance programs. Table 1 on the next page shows similarities and differences among the five diversion programs.

TABLE 1

SIMILARITIES AND DIFFERENCES AMONG DIVERSION PROGRAMS (As of September 1984)

	Effective Date of Legislation	Date Program Implemented	Uses Diversion Evaluation Committee	Required Makeup of Committees	Administrative Physicians Screen Applicants	Monitors and Terminates Participants
Medical Board	January 1, 1980	January 1980	Yes	4 physicians 1 public member	Yes	Yes
Veterinary Board	January 1, 1983	June 1984	Yes	3 veterinarians 2 public members	Yes	Yes
Dental Board	January 1, 1983	Not yet Implemented	Yes	Unspecified	No	Yes
Nursing Board	January 1, 1985	--	Yes	3 registered nurses 1 physician 1 public member	No	Yes
Pharmacy Board	January 1, 1985	--	No*	--	No	Yes*

*The pharmacy board will use employee assistance programs to screen, accept, supervise, and monitor participants. Employee assistance programs are authorized to terminate participants who do not comply with treatment plans.

COSTS FOR ACCEPTING AND MONITORING PARTICIPANTS

We are unable to compare the cost of each function among the diversion programs because data on some of the costs are not available. The dental board cannot provide any cost data because it has not yet implemented its diversion program. Because the veterinary board has been operating a diversion program for only eight months, it has no data on annual costs. Furthermore, data on the veterinary board's costs are incomplete because its diversion program is not adequately monitoring participants' compliance with their treatment plans.

We can provide cost data for the medical board. During fiscal year 1983-84, the medical board spent approximately $425,000 to operate a diversion program for approximately 160 participants. It spent approximately $29,000 for screening and accepting participants into the diversion program. This amount includes salaries for the program manager and for members of the diversion evaluation committees. To monitor participants' compliance with treatment plans, the board spent approximately $192,000. This amount includes salaries for four compliance officers and a deputy program manager. The remaining $204,000 includes the salaries and benefits for the programs' support staff, the costs of rent, and other operating expenses.

CONCLUSION

All of the State's five diversion programs have similar functions, although the methods of implementing the functions differ somewhat. The diversion program of the Board of Pharmacy differs from the others in that it uses employee assistance programs. If the four other diversion programs were consolidated, they could share the function of monitoring participants' compliance with their treatment plans. Because the pharmacy board's diversion program will be structured differently from those of the other boards, it could not be consolidated with the other diversion programs.

RECOMMENDATION

The Department of Consumer Affairs should further evaluate the potential for consolidating the State's diversion programs.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

THOMAS W. HAYES
for Auditor General

Date: December 17, 1984

Staff: Robert E. Christophel, Audit Manager
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December 14, 1984

Mr. Thomas W. Hayes
Auditor General
660 J Street, Suite 300
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Dear Mr. Hayes:

The State and Consumer Services Agency has reviewed the Auditor General Report P-425, "The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse." The Agency concurs that rehabilitation of professionals suffering from alcohol and drug abuse must be consistent with the goal of continually protecting consumers' health, safety and welfare.

We have reviewed the boards' responses relating to the programs evaluated in the report and have attached the individual comments of the respective boards. The Agency believes that the actions taken and/or planned by the boards will correct the deficiencies noted by the auditors. The Department will work with the boards to develop better mechanisms for quality control to alleviate the identified weaknesses in compliance monitoring.

The report recommends that the Department of Consumer Affairs should further evaluate the potential for consolidating the state's diversion programs. The Department is familiar with each of the existing and proposed diversion programs. Each program addresses unique and diverse professional responsibilities. Such programs do not lend themselves to consolidation. Further, if such an evaluation is done, it should be postponed until the results of the new diversion program in the Board of Pharmacy can be included in an evaluation.

Sincerely,

Shirley Chilton

SHIRLEY R. CHILTON
Secretary of the Agency

Attachments

State of California **Department of Consumer Affairs**

Memorandum

To : THOMAS W. HAYES
Auditor General

Date : Dec. 13, 1984

File No.:

via Shirley Chilton, Secretary
State and Consumer Services Agency
via Marie Shibuya-Snell, Director
Department of Consumer Services

From : **Board of Medical Quality Assurance**

Subject: Diversion Program

The Board of Medical Quality Assurance staff has reviewed your report on the Diversion Program. In response, we would like to provide some perspectives that were not covered in the report and set forth specific actions that have been taken since mid-1984, about the time that your auditors completed their survey work. I am enclosing this response, which describes these perspectives and actions in a comprehensive format.

Speaking for the Board, I can say emphatically that we welcome the insight and opportunity your report has given us to improve the Diversion Program. We have a firm commitment to public safety, physician rehabilitation and confidential treatment. The changes we have put into effect have been made in this spirit.

As we point out in the conclusion of our detailed response, we will be most pleased to provide you with any further information, and will provide you with a formal follow-up review in six months.

Thank you for your concern.

KENNETH J. WAGSTAFF
Executive Director

KJW/bh
Enclosure

RESPONSE TO THE AUDITOR GENERAL'S REPORT ON THE DIVERSION PROGRAM

BOARD OF MEDICAL QUALITY ASSURANCE

BACKGROUND ON THE DIVERSION PROGRAM:

The Diversion Program was established by landmark legislation sponsored jointly by the BMQA and the California Medical Association in 1979. It was created to insure a confidential method for diverting from the disciplinary process physicians who were suffering from alcohol or drug abuse or mental illness, and who would be more appropriate candidates for rehabilitation than for formal discipline.

This program does not harbor the incompetent physician who may try to circumvent BMQA discipline by feigning an "illness". Physicians who have participated in this program have recovered from their illnesses and have become rehabilitated. These physicians are evaluated by Diversion Evaluation Committees (appointed by the DMQ), and "contracts" called treatment agreements are individually tailored for each accepted participant. Participants are typically required to attend one or more weekly group meetings of participants, which are monitored by group facilitators -- paid volunteers who are not state employees and who are experienced in substance abuse. The facilitators call headquarters after such group meetings to report on attendance and any concerns about "slips" (possible drug or alcohol use.) Assurance of compliance with the

terms of the treatment agreements is provided by four BMQA employees called compliance officers. Additional ongoing assessment of the participant at his or her practice location is obtained from condition monitors (called "practice monitors" in the report).

INTERNAL ACTIONS TAKEN:

We recognize that the auditors' report contains a number of critical assessments and we will not attempt to minimize them. As pointed out in the report, remedial actions were initiated in mid-1984 by BMQA management. In June, the program's staff instituted a tighter tracking system which will make it easier to document compliance with the provisions of participants' treatment agreements. More importantly, in August the Executive Director instructed the Chief Medical Consultant to conduct a thorough review of the Diversion Program and make recommendations. These recommendations were presented on September 17th and were immediately implemented. In general, they involve closer monitoring of the program by the Chief Medical Consultant with a regular flow of specific data to him. This data comes from two independent sources within the program: from persons responsible for crisis intervention and rehabilitation monitoring, and from those responsible for compliance surveillance and documentation.

Effective November 1, 1984, after consultation with the members of the Division of Medical Quality, the Chief Medical Consultant and experts in the field, the Executive Director undertook a reorganization of the program staff.

The intent of the reorganization is to clarify and delineate the responsibility and accountability of those persons who conduct compliance surveillance versus those who are involved in monitoring the rehabilitative aspects of the program. The reorganization will not violate the confidentiality of participants.

Surveillance of participants to insure compliance with their treatment agreements has now become the prime responsibility of the compliance officers. Monitoring the participants' rehabilitation has become the conjoined responsibility of the group facilitators, the supervisor of physician groups, and the participants' condition monitors. All aspects of surveillance and monitoring are under the direct authority of the program manager in association with the appropriate DEC case consultant.

A new manager is being recruited for the Diversion Program. In the interim, the Chief Medical Consultant is serving as acting program manager.

While these changes restructure the program to eliminate the problems identified in the Audit, there is still a need for future changes. In our specific responses below to each particular finding of the report, we have outlined these changes. These include on-going training for compliance officers and a formal protocol for the roles of the condition monitors as well as the all-important group facilitators. A concerted effort is being made to insure that the compliance officers are aware of their responsibilities, and a

special computer program will be designed to enhance the program's ability to track the status of program participants.

Responses To Each Audit Finding:

1. "SOME COMPLIANCE OFFICERS ARE NOT ADEQUATELY MONITORING PROGRAM PARTICIPANTS"

Response:

A. Monthly participant contacts

Diversion policy does require that the compliance officers visit participants monthly, with certain exceptions. Visits every other month are allowed for some participants depending on individual progress. The new administrative organization was undertaken in part because of lapses in the frequency of some compliance officer visits, as well as reports based on such visits. This occurred partly (as the report points out) because of staffing difficulties including disability and hiring delays. The impact of an increasing number of participants necessitates the addition of at least one compliance officer to the staff. We will be considering budget proposals to this end. In addition, we are instituting a uniform approach to the training of the compliance officers and believe that the realigned administrative organization will improve their supervision.

The core activity for the rehabilitation of the participant has been the physician group. These groups are led by a facilitator who has background and expertise in the field of drug and alcohol abuse. The responsibilities and role of the facilitators, as adopted early in the program's development, are vital for monitoring each participant. Immediately following each group meeting (and during, if necessary), facilitators routinely report the status of participants. Facilitators report possible drug use, attendance (who attended, who did not attend), whether there were any problems apparent or stated, including whether there had been any "slips", and other pertinent information. Facilitators may take urine samples. The group facilitators provide a direct "eyeball" assessment. Any unfavorable findings become the first step in a system of "exception reporting".

The facilitator's reports have not, until recently, been placed into individual files. The program is now developing and instituting procedures, to include computer-assisted methods, which will insure retention on a case-by-case basis of all pertinent information received from the facilitators. Care must and will be taken to preserve confidentiality.

B. Body Fluid Sampling

The report is correct that the program's policy requires compliance officers to take urine samples once a month. In addition, however, the group facilitators can and do take such samples at random. Further, some participants are subject to random sampling by condition monitors

or other work associates. The program is instituting tighter documentation procedures to insure that all participant urine samples are obtained at the required monthly interval.

In summary, the program will implement a more intensive training effort to inform all compliance officers as to their responsibilities in this area. The new administrative changes will insure accountability. The training and instructions for the compliance officers will include complete instructions on the proper handling of specimens, timely submission to the lab and the coordination (via facilitator, or condition monitor) of the ongoing collection process itself.

C. Record Keeping

Standard policy calls for written visit reports to be sent by compliance officers to headquarters. The auditors have found that some of these reports are not entirely accurate and do not always reflect the terms of the treatment agreement. Some of this may be due to inadvertent errors in the use of the reporting form. We concur that a tracking system for these reports is important and have had such a system in effect since June of this year. We will continue to make improvements. In general, we concur with the auditor's recommendation as to the ongoing training of the compliance officers. We will insure that their training emphasizes their role in insuring the individual participant's adherence to his or her treatment agreement.

2. "SOME CONDITION MONITORS ARE NOT EFFECTIVELY CARRYING OUT THEIR RESPONSIBILITIES"

Response:

A. Several instances were cited where a participant failed to obtain and be monitored at the practice location by a condition monitor. We concur that all facets of the treatment agreement must be strictly adhered to, and will instruct the compliance officers to assure that all monitoring assignments are carried out.

The report refers to situations where participants were monitored by other participants. These are exceptional circumstances which have been selectively approved in each instance. Physicians who are in recovery and have successfully completed the program do make excellent physician monitors and are utilized throughout the state on hospital physician well-being committees.

B. The auditors state that, "Monitors lack knowledge as to their responsibilities and often have no copies of the treatment agreement. Further, compliance officers do not routinely contact them." We concur that monitors should be privy to the agreement and that monitor contacts should be initiated by the compliance officers on a routine basis. We will look into each instance cited by the auditors. It will be the responsibility of the program manager to see that the condition monitors obtain copies of the treatment agreement. In general, it has been and will continue to be the policy of the program to

actively involve these condition monitors. Duties and responsibilities of monitors will be spelled out and distributed on a uniform basis.

C. The audit observed a "lack of detailed descriptions of monitor's duties, recommended guidelines and descriptions of functions for monitors, including quarterly report formats." The report recommends "training for compliance officers in monitor duties and development of ongoing assistance to insure that monitors are fulfilling their responsibilities."

We will strengthen the existing training now given to compliance officers to incorporate the auditors' suggestions. In addition, the streamlined administrative approach now in place will assure that compliance officers are fulfilling their responsibilities. This should maintain and improve dissemination of information and accountability system-wide. The program will insure that each compliance officer is in continuing contact with a monitor for each participant. Quarterly reports will be emphasized.

3. THE REPORT FINDS THAT THERE HAVE BEEN DEFICIENCIES IN ACTIONS TAKEN CONCERNING THREE SITUATIONS WHERE RECORDS SHOW PARTICIPANTS SHOULD HAVE BEEN SUSPENDED FROM PRACTICE. THE REPORT PROVIDES DETAILS ON TWO OF THESE.

Response:

As indicated in the report, a physician Board Member and the Chief Medical Consultant, based on the auditors' report of the record, concurred with the auditors' conclusions. The problem in these instances appears to be the lack

(-8-)

of documentation in the file concerning conversations between the group facilitator, program manager, and the case consultant concerning instances of "slips" by the individual participants. Both of the participants detailed in the report were individuals who required repeated counseling. Unfortunately, this was not noted in the case file. "Judgement calls" by the program manager based upon input from the facilitator, compliance officer, and condition monitor must occasionally be made, as was the case in these instances. In both cases it was decided to keep the individuals in practice. Ultimately, the two individuals violated this trust and were suspended from practice by the authorities at their practice location.

In general, we concur with the focus of the report. Efforts are now being made to improve not only the quality and content of the documentation necessary to insure compliance, but to insure immediate and appropriate response. Where serious noncompliance occurs, the case consultant and the DEC must always be consulted. It is the highest priority of the program to assure the public that no participant can ever successfully attempt to practice while using alcohol or drugs.

In the first example cited, where the program manager did not suspend a participant from practice, the individual participant was removed from practice by the condition monitor on the scene. Under the law, the participant's removal from the medical staff was reported to the BMQA (Section 805, B&P Code). While the direct intervention of the program manager was not

necessary in this particular instance, it is understood that wherever the manager receives information of this kind it is reported to the case consultant so that an immediate decision can be made. The program manager has the authority to remove the physician from practice as part of the participant's agreement. The program manager will not hesitate to exercise this authority.

Of the three cases cited above by the auditors as problem participants, two are described as candidates for expulsion from the program. It is the policy of the program to provide full information on such incidents to the Diversion Evaluation Committee (through the case consultant) for appropriate disposition. The Committee must make the determination as to whether the person will continue in the program. It is imperative that the program manager continue to make such referrals. An inquiry into the apparent failure to refer these persons to the DEC is now being pursued. As part of the overall policy assessment that has been undertaken, and in association with the administrative changes now in place, we will develop and implement specific criteria for such immediate referral. Further, we agree with the auditors on the importance of assuring full communication between the program manager and the Diversion Evaluation Committees.

4. "LACK OF OVERSIGHT" BY THE BOARD AND EXECUTIVE STAFF

Response:

The auditors' recommendations are consistent with the ongoing changes now underway. Over the last six months, there has been clarification of the

authority of the Chief Medical Consultant, as well as a reorganization of the program. The duties and responsibilities of the program manager, the relationship between the manager and the compliance officers, the functions of group facilitators and condition monitors -- all of these things have been reviewed, clarified, and strengthened. Inherent in this reorganization of staff is the development of new reporting procedures, consistent with confidentiality, to insure that documentation for all participants is complete and up-to-date. The new program manager will have day-to-day, over-all responsibility. The Chief Medical Consultant will continue to exercise broad policy supervision.

Summary:

The Board of Medical Quality Assurance appreciates the review, advice and recommendations of the auditors. We take our responsibilities seriously and intend to keep improving the program. The Diversion Program is an important and sensitive activity, dedicated to the rehabilitation of physicians and the protection of the public. In this spirit, the Board welcomes the AG review and will report on our progress in six months.

DEPARTMENT OF
Consumer Affairs
1020 N STREET, SACRAMENTO, CALIFORNIA 95814
(916) 920-7662

December 13, 1984

Mr. Thomas W. Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for the opportunity to respond to your draft report entitled, "The State's Diversion Programs Do Not Adequately Protect The Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse." I will be responding to that section of the report which deals with the Board of Examiners in Veterinary Medicine.

The draft report contains three specific recommendations which I will respond to in order:

Recommendation: Develop a system to monitor the program manager's performance to ensure that the program manager is implementing appropriately provisions of state law and of his contract, including proper screening of applicants.

The Executive Officer of the Board has established a procedure where meetings will be held with the program manager on a bi-monthly basis in conjunction with regularly scheduled Board meetings. During these meetings, the following elements will be reviewed:

1. The number of program participants.

2. In-depth discussion of the status of each case as it relates to compliance and non-compliance in terms of the contract agreement.

3. Monitoring the daily activities of the program manager, including a review of his travel and program expenses.

Part of this recommendation is to develop a system to monitor the proper screening of applicants. Criticism in the report cited examples of not meeting the legislative mandate to require that a physical be given by an administrative physician prior to acceptance into the program.

Individuals originally admitted into the program were actively participating in rehabilitation programs on a voluntary basis and had been subjected to varying degrees of medical evaluation. The program mamager saw no reason to duplicate this; however, all future applicants admitted to the program will be screened to meet the legislative mandate.

Recommendation: Develop specific performance standards in the program manager's contract for monitoring participants, including the frequency with which the program manager should contact participants and collect urine samples.

The original contract was developed with the assistance of legal counsel in an attempt to make the standards as specific as possible. The contract for 1985/86 will be refined to include the recommendations of the Auditor General, including a specific recommendation that urine samples be collected on a specific periodic basis.

Recommendation: Augument the diversion program's budget by contracting for the services of a compliance officer to monitor the program's participants.

The Board of Examiners in Veterinary Medicine does not agree with this recommendation in that the use of volunteers has proven to be cost-effective and responsive to monitoring and retaining compliance. The Auditor General's report did not reflect any deficiencies in this system and, therefore, the Board sees no reason to alter the current procedure.(1)* The Executive Officer will, however, under the more strictly defined monitoring process, closely review, with the program manager, the qualifications of the people chosen to be compliance monitors.

In addition to the specific recommendations contained in the report, the Attorney General points out that there was an 18-month delay in fully implementing the program. During this 18-month period, the Board was concurrently developing regulations and implementing an outreach education program, which gained support of the community and professional groups. This was a key element in assuring that, upon implementation, the confidence level would be such that the program would encourage participation by professionals.

Thank you, again, for the opportunity to review the draft report. If you or other staff have any specific questions, please feel free to contact me.

Sincerely,

GARY HILL, Executive Officer
Board of Examiners in
Veterinary Medicine

* The Auditor General's comments on specific points contained in the agency's response begin on page 77.

DEPARTMENT OF Consumer Affairs

BOARD OF DENTAL EXAMINERS
1430 HOWE AVENUE, SUITE 85B, SACRAMENTO, CALIFORNIA 95825
TELEPHONE: (916) 920-7451

December 13, 1984

Thomas W. Hayes, Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

I appreciate the opportunity to formally respond to the draft report of the Auditor General, entitled "The State's Diversion Programs Do Not Adequately Protect The Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse", and particularly the chapter which deals with the Board of Dental Examiners.

I have the following comments: The report accurately reflects the status of the Board's diversion program. However, certain technical errors appear to have been made. This report identifies 12 cases that were reviewed. Based on the auditor's review, the conclusion was made that the Board has improperly handled dentists suffering from alcoholism or drug abuse. The conclusion appears to be based on the supposition that these individuals would have been candidates for the diversion program. (2) A supposition that cannot be documented. Had the Board's diversion program been operational, it is speculation as to whether any of the cases reviewed by the auditor would have resulted in diversion of the subject. The important fact to remember is diversion by design is used only for those specific cases where there is reasonable evidence and assurance that diversion from discipline is in the best interest of the public. This judgement rightfully would have to be made on the basis of the individual and by professionals competent to make such judgements.

The report cites two specific cases. I will address one case in which there appears to have been a misunderstanding of the facts. (3) The dentist in question was under investigation as a result of his arrest for violation of Health and Safety Code Section 11173. On the advice of the Attorney General, the Board withheld filing an accusation until the criminal proceedings were completed. (4) However, the record also reflects that at the time of the arrest, the subject had sold his dental practice and was no longer treating patients. The criminal proceedings resulted in a stay of the counts with the stipulation that the subject be placed in a criminal diversion program. Although the Attorney General recommended the subject to the Board's diversion program, it is questionable whether such would have been necessary in view of the criminal stipulation. It is true that a year lapsed and no action was taken until November 1984, however, I feel it should be stated that during the time period, the former executive officer resigned. When the Executive Officer position was filled, the Attorney General's recommendations were acted upon. The subject dentist currently is not practicing and has been free of drugs for almost 2 years. (5)

The Board of Dental Examiners has not yet implemented a diversion program for the following reasons: The composition of the Board has changed, and during this time the Executive Officer position was vacated. The Board recognizes the diversion program as an important program but was unable to implement the program due to lack of resources to address many statutory mandates.

However, the conclusion that the Board is not disciplining some dentists suffering from alcoholism or drug abuse is not an accurate reflection of the Board's efforts to protect the public. Under my direction, cases that had been recommended for diversion are being rechanneled through the disciplinary track. Further, of the disciplinary cases reviewed, the terms of probation have included surrender of the DEA registration, practice under supervised conditions, and other specific practice restrictions. (6)

Recommendations:

1. The Auditor General has recommended that the Board, within six months from the date of the report, prepare regulations to implement a diversion program. Six months may not be a realistic time frame for the Board to develop regulations. The staff will present the issue of the diversion program to the Board.

2. The regulations should establish criteria for adopting and denying applicants and terminating participants. This issue will be encompassed into the staff report to the Board.

3. Once the regulations are adopted the Dental Board should hire staff to implement and commence accepting dentists. The enabling regulations did contain an authorization to hire staff. Thus this recommendation cannot be implemented. (7)

Conclusions:

The Board recognizes the importance of the diversion program and will take action to implement the program as soon as reasonably possible.

Sincerely,

BOARD OF DENTAL EXAMINERS

Georgetta Coleman

GEORGETTA COLEMAN
Executive Officer

AUDITOR GENERAL'S COMMENTS ON THE STATE AND CONSUMER SERVICES AGENCY'S RESPONSE

The comments that follow address specific points made by the agency. The numbers correspond to numbers we have placed in the agency's response.

(1) The veterinary board's response states that the report does not reflect deficiencies in the use of volunteers to monitor the diversion program's participants. The report recognizes that the program manager uses volunteers from the community to assist him in monitoring participants. However, the report also notes that because these volunteers are not state employees or employees of the program manager, they are not accountable to the program manager. In addition, the report points out that the program manager has not implemented adequate systems for monitoring participants' compliance with their treatment plans. The program manager told us that he does not have time to monitor participants' compliance adequately since he works only half-time for the diversion program. (See pages 37 through 39 of the report.)

(2) The dental board's response states that our conclusion that the board has not properly handled dentists suffering from alcoholism or drug abuse is based on the supposition that the dentists would have been candidates for the diversion program. The report does not state that these dentists would have been candidates for the diversion program. The report does state that, in the absence of a diversion program, dentists suffering from alcoholism or drug abuse do not have the opportunity to enter a rehabilitation program as an alternative to disciplinary action, and the dental board has not disciplined some dentists suffering from alcoholism or drug abuse. (See pages 43 through 46 of the report.)

(3) The dental board states that "in one case there appears to have been a misunderstanding of the facts." We reviewed all the facts contained in the dentist's case file and discussed this case with the dental board. As of December 4, 1984, the dental board has not provided us with any additional documentation to refute any statements in the report. (See pages 45 and 46 of the report.)

(4) The dental board states that "on the advice of the Attorney General, the board withheld filing an accusation until the criminal proceeding was completed." However, the deputy attorney general told us that the proceedings were complete as of July 7, 1983, and that he had recommended that the dental board proceed with disciplinary action by executing the accusation.

(5) The dental board states that "the subject dentist currently is not practicing and has been free of drugs for almost two years." However, as of December 4, 1984, we found no evidence in the dentist's file to support this statement. The dentist is still free to practice dentistry without any restrictions on his license.

(6) The dental board states that ". . . of the disciplinary cases reviewed, the terms of probation have included surrender of the DEA [Drug Enforcement Administration] registration, practice under supervised conditions, and other specific practice restrictions." Four of the 12 cases that we reviewed were probation cases; we found no evidence that these four dentists complied with terms of their probation.

(7) The dental board has informed us that the second and third sentences in this paragraph should read, "The enabling legislation did not contain an authorization to hire staff. Thus, this recommendation cannot be implemented." On page 47 of the report, we note that the dental board received an appropriation for fiscal year 1983-84 of $42,000. These funds have been carried over for fiscal year 1984-85. These funds are available to contract for services.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps